

Michigan Department of Licensing & Regulatory Affairs  
**Athletic Trainer Board**  
P.O. Box 30670  
Lansing, MI 48909  
(517) 335-0918  
[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)

## **ATHLETIC TRAINER RELICENSURE INSTRUCTIONS**

Authority: P.A. 368 of 1978, as amended

This form is for information only.

**NOTE:** It is your responsibility to have all required documentation sent to the Athletic Trainer Board. Questions regarding your application can be directed to the Athletic Trainer Board at (517) 335-0918 three weeks after the date you submit the application. Please allow 6-8 weeks processing time. If an applicant fails to complete the requirements for relicensure within two years from the date of filing the application, the application is no longer valid.

### **INSTRUCTIONS FOR RELICENSURE APPLICATIONS SUBMITTED BEFORE SEPTEMBER 30, 2014:**

1. Complete the application and return it to the Athletic Trainer Board with the appropriate fee. A check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany the application. An application accompanied by the appropriate fee is valid for two years. Applications received without a fee will be returned.
2. Verification of licensure from any state where you hold or have ever held a permanent athletic trainer license must be sent to the Michigan Board from the other state(s). A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.

### **INSTRUCTIONS FOR RELICENSURE APPLICATIONS SUBMITTED AFTER SEPTEMBER 30, 2014:**

1. Complete the application and return it to the Athletic Trainer Board with the appropriate fee. A check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany the application. An application accompanied by the appropriate fee is valid for two years. Applications received without a fee will be returned.
2. Arrange for the Board of Certification, Inc (BOC) to provide official verification of your current certification status to the Michigan Board. The official written verification must be submitted directly from BOC. You may contact BOC via their website: [www.bocatc.org](http://www.bocatc.org). The Michigan Athletic Trainer Board does not allow for electronic verifications to be sent from BOC.
3. Submit proof of completion of at least 1 hour of BOC approved continuing education in pain and symptom management that was obtained within the 3 years immediately preceding your application for relicensure.
4. Submit a photocopy of documentation of current certification in emergency cardiac care from an organization that provides training using the standards of emergency cardiac care for professional providers from either the American Heart Association or the American Red Cross.
5. Submit a photocopy of documentation of a minimum of 1 hour of first aid training received in the 3 years immediately preceding the date of submitting this license application. The first aid training must be offered by the American Red Cross or another organization that provides substantially equivalent first aid training.
6. Verification of licensure from any state where you hold or have ever held a permanent athletic trainer license must be sent to the Michigan Board from the other state(s). A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.

## **GENERAL INFORMATION**

1. **NAME AND/OR ADDRESS CHANGES:** If there is a change in your name and/or address, please notify the Athletic Trainer Board in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website [www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense) and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. **REFUND POLICY:** If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Athletic Trainer Board in writing to request a refund.
3. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 333.16174 (2). Sanctions include probation, limitation, suspension, revocation or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license.
4. **CONTINUING EDUCATION:** There is a continuing education requirement for renewal starting with the licensing cycle from October 1, 2011 to September 30, 2014. Please check our website at [www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense) for more information.

**PLEASE NOTE:** You are not required to complete any continuing education credits in order to renew your license for the first time after this relicensure process because you will not have held the license for a full three-year period. Licensees will be expected to maintain current certification in first aid and emergency cardiac care in order to renew.

5. **ONCE YOU ARE RELICENSED, YOUR LICENSE WILL BE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE VALID FOR A THREE-YEAR PERIOD.**



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

STEVEN H HILFINGER  
DIRECTOR

**CRIMINAL BACKGROUND CHECK  
FINGERPRINT REQUEST FORM INSTRUCTIONS- (Michigan locations only)  
AGENCY ID NUMBER IS 71734k**

Applicants for a Michigan health professional license may have their fingerprints taken by either L-1 Identity Solutions or Cogent Systems. Whether you use L-1 Identity Solutions or Cogent Systems, the Agency ID Number for health professional licensing is 71734k. This ID number MUST be used in order to have your fingerprint report sent to the Bureau of Health Professions. Keep the receipt you receive once your fingerprints are taken.

You must bring the Livescan Fingerprint Request Form (attached) and a driver's license or other state or federal-issued picture identification to your fingerprint appointment. You will also be required to pay a separate fee to the fingerprinting agency when registering for or scheduling your appointment.

When your fingerprints are taken, a technician will perform a scan of your fingerprints and submit the data electronically to the Michigan State Police. If no criminal history is found, the Bureau of Health Professions will be notified. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.

Information about fees and scheduling your fingerprint appointment with L-1 Identity Solutions can be found at [www.L1enrollment.com](http://www.L1enrollment.com) or by calling 1-866-226-2952.

Information about fees and registering to have your fingerprints taken by Cogent Systems can be found at [www.cogentid.com/index.htm](http://www.cogentid.com/index.htm). Click on Michigan and then select the Cogent MAPS (Michigan Applicant Processing Service) option. If you are using Cogent Systems, the MAPS option must be used for health professional licensing purposes. Cogent Systems can be reached by phone at 1-877-838-4903. E-mail inquiries about using Cogent Systems may be sent to [mihelp@cogentsystems.com](mailto:mihelp@cogentsystems.com).



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STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
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**CRIMINAL BACKGROUND CHECK  
FINGERPRINT REQUEST FORM INSTRUCTIONS  
(For applicants out of state or out of country)**

1. Contact a local law enforcement , governmental, or private fingerprinting agency to see if they can perform an ink fingerprint on an FBI (FD-258) card or on another state's official fingerprint card. The ink fingerprint must be completed on card stock.
2. Submit the card with your fingerprints, the completed Livescan Fingerprint Request Form (attached) and a business check or money order for \$62.75 made payable in U.S. Funds to L-1 Identity Solutions to the following address:

L-1 Enrollment Services/LiveScan Processing Unit  
1650 Wabash Ave. Ste. D  
Springfield, IL 62704

3. Please include a daytime telephone number or e-mail address where you can be reached if there are any questions.
4. L-1 Identity Solutions will submit your fingerprints to the Michigan State Police for analysis.
5. If no criminal history information is found, the Bureau of Health Professions will be notified.
6. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.
7. Call L-1 Identity Solutions toll-free at 1-866-226-2952 (8 am - 5 pm EST) if you have any questions.
8. L-1 Identity Solutions is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 241-0606.

Michigan Department of Licensing and Regulatory Affairs  
**Bureau of Health Professions**  
P.O. Box 30670  
Lansing, MI 48909  
(517) 335-0918

LARA/300L (04/11)

## LIVESCAN FINGERPRINT REQUEST FORM

Fingerprint Date:	TCN:
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Type of I.D. Presented:	Type of Licensure/Registration:
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**Applicant Instructions:** Take this completed form along with your picture I.D. to your scheduled appointment. Please print clearly.

First Name:	Middle Name:	Last Name:	
Street Address:			
City:	State:	ZIP Code:	
Daytime Telephone Number w/ Area Code:		State or Country of Birth:	
Date of Birth (MM/DD/YYYY):	Race:	Sex:	
Height:	Weight:	Eye Color:	Hair Color:

### REQUESTING AGENCY INFORMATION

Agency I.D. Number: <b>71734k</b>	Agency Name: <b>Department of Licensing and Regulatory Affairs, Bureau of Health Professions</b>
Reason Fingerprinted: <b>LHP - Licensed Health Care Professional (MCL333.16174)</b>	Cost:

**\*\*Disclaimer:** Any and all errors that result in dual fingerprinting (Duplicate transmission to MSP), multiple fingerprint codes, fingerprints processed with incorrect fingerprint codes/reasons, etc., are the responsibility of the **LIVESCAN AGENCY**. **MSP** will charge for dual fingerprinting (transmission), etc.

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**APPLICATION FOR RELICENSURE**

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, a license will not be issued.

**Type or Print Only****Board Use Only****I AM APPLYING FOR THE FOLLOWING:**

License Number:

Date of License:

☐ Relicensure Fee: \$295.00 71-2601-06

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Telephone Number
Street Address		E-mail Address
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		Michigan Health Professional Permanent I.D./License Number and Expiration Date
Has your Michigan athletic trainer license been lapsed more than three years?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Check the appropriate answer to each of the following questions. NOTE: Submit a detailed explanation for any YES answer you check on a separate sheet with your application.**

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?

☐ Yes ☐ No

List each state(s) or US territory in which you hold or have ever held a permanent athletic trainer license, the license number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)**

State	License Number	Date of Issue	How was it obtained (Endorsement or examination)

### CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant

Date

## Michigan Department of Licensing and Regulatory Affairs

## Bureau of Health Professions

P.O. Box 30670

Lansing, MI 48909

www.michigan.gov/healthlicense

## VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

**PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.**

Check the profession for which you are requesting verification.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Acupuncture       | <input type="checkbox"/> Marriage & Family Therapy | <input type="checkbox"/> Osteopathy             | <input type="checkbox"/> Respiratory Therapy       |
| <input type="checkbox"/> Athletic Trainers | <input type="checkbox"/> Medicine                  | <input type="checkbox"/> Pharmacy               | <input type="checkbox"/> Sanitarian                |
| <input type="checkbox"/> Audiology         | <input type="checkbox"/> Nursing                   | <input type="checkbox"/> Physical Therapy       | <input type="checkbox"/> Social Work               |
| <input type="checkbox"/> Chiropractic      | <input type="checkbox"/> Nursing Home Admin.       | <input type="checkbox"/> Physician's Assistants | <input type="checkbox"/> Speech-Language Pathology |
| <input type="checkbox"/> Counseling        | <input type="checkbox"/> Occupational Therapy      | <input type="checkbox"/> Podiatry               | <input type="checkbox"/> Veterinary Medicine       |
| <input type="checkbox"/> Dentistry         | <input type="checkbox"/> Optometry                 | <input type="checkbox"/> Psychology             |  |

First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.  
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

**PART II: To be completed by the State Licensing Board.**

Type of License:	Original Issue Date	Expiration Date
Basis for Issuance of License:		
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____		
<input type="checkbox"/> Endorsement - Please indicate name of state _____		
License Status	Has the applicant incurred any formal or informal actions in your State?	
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.	
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**CERTIFICATION**

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board